Description of Data and/or Narrative Reports to be Submitted by Plans to the State

Data and narrative reports to be submitted by plans to the State in order to support the QAP identified in Standards for Internal Quality Assurance Programs in this document to include the following:

I. **A** written QAP description submitted annually in narrative form to include:

a. goals and objectives,
b. scope,
c. specific activities,
d. continuous activities,
e. provider review and, and
f. a focus on health outcomes.

11. An ongoing systematic process of quality assessment and improvement to include:

a. An annual written specification of the clinical or health service areas to be monitored in accordance with focused study guides developed in conjunction with the Oklahoma Foundation for Medical Quality. The minimal clinical areas to be monitored are as follows:

1. Childhood immunizations,
2. Pregnancy,
3. Comprehensive Well Child Periodic Health Assessment, and
4. Asthma.

b. An annual written cumulative analysis and evaluation of the quality indicators and clinical care guidelines data to identify and document service areas requiring improvement.

c. An annual written remedial or corrective action plan which includes:

1. specification of the types of problems requiring remedial/corrective action;
2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;
3. specific actions to be taken;
4. provision of feedback to appropriate health professionals, providers and staff;
5. the schedule and accountability for implementing corrective actions;

6. the approach to modifying the corrective action if improvements do not occur;
7. procedures for terminating the affiliation with the physician, or other health professional or provider; and
8. the effectiveness of the corrective action plan including changes in data on the targeted clinical areas above.

III. Annual written documentation reflecting QAP accountability to the Governing Body to include the following:

a. QAP oversight functions,
b. QAP progress reports,
c. annual QAP review, and
d. program modification.

IV. Annual written documentation of program QA committee activities and structure including:

1. regular meetings,
2. established parameters for operating,
3. documentation,
4. Accountability, and
5. membership.

V. Annual written documentation of QAP supervision indicating the involvement of the Medical Director.

VI. Annual written documentation and verification of adequate resources to meet HMO plan service and documentation requirements to include:

a. staffing,
b. licensure and accreditation requirements, and
c. financial solvency.

VII. Annual written documentation of all program provider participation in the QAP process and dissemination of QAP information including the findings or results of the QAP process.

VIII. Annual written documentation of HMO accountability of QAP functions in the event of delegation of QAP including:

a. a written description of the delegated activities, and
b. written procedures for monitoring and evaluating the delegated functions including evidence of continuous and ongoing evaluation,

IX. Appropriate annual written documentation of credentialling and recredentialling of physicians and other health care professionals in accordance with Standard IX of the Standards for Internal Quality Assurance Programs in this document to include:

a. written policies and procedures,
b. oversight by governing body,
c. credentialling entity if delegated including credentialling activities delegated,
d. scope of providers falling under credentialling process,
e. credentialling process to include all elements of Standard IX E and F,
f. retention of credentialling authority,
g. reporting requirements for quality deficiencies, and
h. provider appeals process for credentialling and recredentialling.

X. Appropriate annual written documentation of the organizations commitment to enrollee rights and responsibilities in accordance with Standard X of the Standards for Internal quality Assurance Programs including an Assessment of Member Satisfaction to include:

a. written policy on client rights and responsibilities,
b. methods of the communication of policies to providers,
C methods of communication of policies to client members,
d. client grievance procedure,
e. steps taken to assure accessibility,
f. methods for the dissemination of appropriate written information to clients,
g. confidentially of patient information in keeping with Standard X I,
h. written policy ensuring the appropriate treatment of minors, an 1
1. an assessment of client satisfaction in keeping with the client satisfaction survey developed by the State. The State will develop a standardized survey instrument for client satisfaction including a reporting format.

XI. Annual written documentation of standards for availability and accessibility in keeping with minimal state requirements as identified in Protocol 2 of this document.

XII. Ongoing documentation of medical records ensuring availability for review of the independent external quality review organization designated by the State and any state or federal audits required. Records should be maintained in accordance with the medical records standards in Standards for Internal Quality Assurance Programs to include:

a. accessibility and availability of medical records,
b. recordkeeping in accordance with QARI documentation requirements specified in Standard X B, and
c. record review process.

XIII. Written annual documentation of a written utilization management program in compliance with Standards for Internal Quality Assurance Programs as identified in this document. The Oklahoma Foundation for Medical Quality will conduct Utilization Review studies in the areas identified in QARI Standard XIII. The MCO written documentation of utilization management will include:

1. a written program description,
2. program scope to detect under and overutilization, and
3. pre-authorization and concurrent review requirements.

XIV. Written annual documentation ensuring a basic continuity of care system in accordance with Standards for Internal Quality Assurance Programs and State requirements.

XV. Ongoing documentation of the QAP in accordance with Standards for Internal Quality Assurance Pronrams. Such documentation must be made available to the State upon request and as scheduled.

XVI. Annual written documentation of QA activities with other management activity in accordance with Standards for Internal Quality Assurance Programs, as identified in this document to include the following:

1. recredentialling, recontracting, and/or performance evaluations;
2. utilization management, risk management, and resolution and monitoring of client complaints and grievances; and
3. other management functions.

Current Status of MCO Outpatient Monitoring

During the months of June and July, all participating plans in the 1915(b) program received an initial readiness review to determine their ability to initiate enrollment and begin providing services. As a part of that readiness review, the State examined the status of each plan's Quality Assurance and Medical Management components. This assessment was conducted using a standardized instrument that requested detailed information from each MCO concerning its Quality Assurance Plan and that plan's conformance with QARI.

None of the MCOs were found to be in full compliance with ***QARI*** at the time of the reviews. However, the assessments results were used by the State and MCOs as a tool for

defining in precisely which areas additional work was required. The State is currently meeting with the plans individually to develop a phased in compliance plan where needed, and to work out a schedule for monitoring in areas indicated as fully in ccmpliance. The State will administer another baseline assessment in the Spring of 1996 in order to determine movement toward compliance indicated in the phased in compliance plans.

PCCM Monitoring

Since QARI was developed for fully integrated, MCO type managed care plans, all of the elements do not easily transfer to the rural, partially capitated delivery systems which also will be operated under the 1115(a) waiver. The monitoring standards will, therefore, differ for health plans and partially capitated providers.

The State itself will be performing some functions of an MCO under QARI in order to accommodate as much of the QARI process as possible. The State will extract relevant components of QARI into its reporting and monitoring standards for rural providers participating under partial capitation arrangements. Attachment 11 contains an application which must be completed by all physicians desiring to participate in *SoonerCare* as primary care case managers. This form incorporates components of QARI which are currently used as provider standards for MCOs. The State monitoring process will be ongoing and compiled annually. The QARI components selected will be compatible with the *Medicaid Primary Care Case Management Programs: Guidefor Implementation and Quality Improvement* developed by the APWA for HCFA.

These will include QARI standards for a minimal QAP description, applicable focused studies, credentialling and recredentialling, enrollee rights and responsibilities, and medical records standards. As with the QARI Guidelines, it is recognized that not all PCCM providers currently meet the identified standards. Therefore the states will work with providers to encourage and support full compliance or a phased-in compliance.

The eight elements of PCCM programs identified in the *Medicaid Primary Care Case Management Programs: Guidefor Implementation and Quality Improvement* that need to be established and monitored as part of the waiver process are as follows with reference to QARI Standards one through sixteen indicated above:

1. Provider Enrollment and Education

The State will accommodate QARI Standard IX Credentialling & Recredentialling for Provider Enrollment. Standard IX A,B,C,and D will be maintained as a State function. QARI Standard IX E 1-13, will be the criteria by which PCCM applicants will be evaluated by the State to become PCCM providers. The State will maintain QARI Standard IX F-J for PCCM provider recredentialling.

The State will accommodate QARI Standard IV E in order to obtain provider input into the State PCCM QA functions. The State will also use QARI Standard I E to ensure provider input and feedback in **QA** activities. QARI Standard X C will be used in order to communicate State policies on patient rights and responsibilities.

2. Client Enrollment and Education

The State will establish a commitment to the treatment of members in a manner that acknowledges their rights and responsibilities and ensures appropriate education and information dissemination by using all relevant elements of QARI Standard X both with clients and providers in the educational process and with clients in the enrollment process. The client satisfaction and grievance process in Standard X will be covered in PCCM element ***6.***

3. Access

The State will establish and monitor appropriate service access by using QARI Standard XI in order to establish standards for access to routine, urgent, and emergent care; telephone appointments, advice, and member service lines. PCCM providers will be monitored using these access standards. QARI Standard X G will be provided by the PCCM with its provision monitored through the State.

4. Primary Care Services

The Primary Care Services for which PCCM providers will be responsible are identified in Protocol Question 4 of this document. These services will be monitored through the Utilization Review process identified in QARI Standard XIII and in the focused studies identified in QARI Standard 11.

5. Specialty Services/Referrals

Specialty service referrals for PCCM providers will be monitored as a function of the Utilization Review process identified in QARI Standard XIII A-C. Particular attention will be paid to both over and underutilization of referrals as identified in X B.

6. Client Satisfaction Grievance Procedures

The State will use QARI Standard X E for resolving client complaints and formal grievances. The process has all elements of QARI **X** E 1-5. The State will monitor client satisfaction through QARI Standard X K 1-4 through an annual client satisfaction survey with clients receiving the services of PCCM providers. The survey process will provide for feedback to PCCM providers to use in the Quality Improvement process.

7. Medical Records

The State will use all elements of ***QARI*** Standard XII in order to monitor PCCM records. The State will monitor a sample of PCCM records annually for compliance with Standard XII.

8. Utilization Management

The State will monitor Utilization Management through QARI Standard XIII as identified above. **As** part of the continuous monitoring and evaluation activities of the QAFU targeted clinical areas of concern, the State will compile statistics on EPSDT and prenatal service delivery. In rural Oklahoma, the introduction of a primary care capitation and special participation incentives for rural health clinics should result in improved access to care for children and pregnant women. In metropolitan areas, similar outcomes should occur through enrollment of Medicaid beneficiaries into pre-paid health plans.

8. ADMINISTRATIVE AND INFORMATION MANAGEMENT SYSTEMS

Introduction

This section describes the administrative and operational management system of the Oklahoma Health Care Authority as it relates to the Title XIX program. In addition, it describes in detail the information management system which is used by the Authority in operation of the State's Medicaid program.

Overview

The Oklahoma Health Care Authority is governed by a seven-member Board, appointed by the Governor, President Pro Tempore of the State Senate, and Speaker of the State House of Representatives. Terms of the Board are from one to four years.

The Authority operates under the direction of an Administrator appointed by the Governor and confirmed by the State Senate. The current Administrator is Garth L. Splinter, M.D., M.B.A. Dr. Splinter is responsible for overseeing all activities of the agency, including administration of personnel and budgeted funds, setting agency priorities, developing a strategic plan, and carrying out the mission of the Authority.

The Health Care Authority contains five major operational areas:

- Managed Care
- Medicaid Operations
- Health Policy and Planning
- Information Services
- Medical Division

Each of these operational areas is overseen by a senior agency administrator who reports directly to the Administrator. In addition to these divisions, the Authority has a number of administrative support units, all of which report to the Chief of Staff. The Chief of Staff reports directly to the Administrator. (See Attachment 12 for an organizational chart of the Oklahoma Health Care Authority.)

Following is a description of each operational area and administrative support unit:

Managed Care Division

Specific responsibilities for the Managed Care Division are:

- ***Providing technical assistance to MCOs/outpatient networks/providers in network or primary care development.*** The Managed Care Division, in collaboration with the

Business and Contracts Manager, the Medical Director and the Information Services Division, is responsible for assisting potential and active MCOs and providers with issues related to development or enhancement of managed care services. In addition, the Managed Care Division and Business and Contracts Manager are responsible for all readiness evaluations, including on-site readiness reviews, for all MCOs.

- ***Monitoring MCO/rural primary care provider operations and financial status to ensure compliance with contract terms & conditions.*** The Managed Care Division develops operational and financial standards for urban MCOs and rural primary care providers. The Division's Financial Analyst, in collaboration with the agency's Finance Division, is responsible for monitoring the performance of both groups against these standards. The division also conducts periodic field audits of MCOs/providers to obtain more detailed information on performance against State and Federal standards.

- *Performing* ***Provider Managed Care Education.*** The division is responsible for education of physicians and other providers about the managed care program and responds to questions/complaints concerning State policies and actions.

- ***Field Operations.*** The division has three Managed Care Coordinators who are responsible, with the Division's Enrollment Unit, for coordinating outreach and education for MCOs/providers, clients and DHS case workers conducting eligibility **and** enrollment. Working with the Business **and** Contracts Manager, they conduct outreach to MCOs which have expressed interest in contracting with the program. Upon referral from the Provider Relations Unit in Medicaid Operations, they answer provider questions and resolve provider problems or complaints when issues are beyond the scope of the Provider Relations Unit. In collaboration with the Business and Contracts Manager and Medical Director, they are also involved with ongoing interactions related to MCOs, include resolution of problems within the MCO networks.

- ***Client enrollment in managed care.*** The Enrollment Unit is responsible for enrollment activities for all clients served through the managed care system. The Unit is responsible for training DHS case workers involved in the enrollment process and for coordinating enrollment activities between the Authority and DHS. In collaboration with the Marketing Coordinator, the Unit is responsible for development and dissemination of materials to managed care enrollees and the Department of Human Services field offices, where eligibility determination occurs. The Unit is also responsible for coordinating the activities of the agency's toll-free enrollment telephone agent, Benova.

- ***Managed care quality assurance.*** The Quality Assurance Manager, Dr. Darendia McCauley, is responsible for ensuring that MCOs are in compliance with QARI standards applicable to them and that all required encounter data is collected in

conformance with HEDIS for Medicaid standards. Dr. McCauley is also responsible for ensuring that encounter data is used to promote MCO quality assurance.

Medicaid Operations

The Medicaid Operations Division has primary responsibility for day-to-day operation of the Medicaid program and coordination of the program with other entities.

Specific responsibilities for the Medicaid Operations division include:

- *Overseeing Program Operations.* The division coordinates eligibility determination activities with the Department of Human Services, conducts Title XIX quality assurance activities in the fee-for-service system (in coordination with the Medical Director's office) and ensures the Health Care Authority is in compliance with Federal requirements in its day-to-day activities. The Division is responsible for monitoring the performance of Title XIX fee-for-service providers against State standards.

- *Claims Adjudication.* The Division is responsible for processing fee-for-service claims and distributing warrants for these services. It is also responsible for third-party liability recovery for services delivered outside of managed care.

- *Provider and Client Relations.* The Division is responsible for all contacts with fee-for-service providers and initial interactions with providers within health networks and primary care case managers. Questions or issues beyond the scope of this unit are referred to the Managed Care Division.

- *Long Term Care Unit.* Responsible for payment and adjudication of long term care claims.

- *Third-party Liability:* Responsible for identification and collection within the fee-for-service system of all sources of third-party payments

- Additional units within this division include on-site review and fee-for-service quality assurance.

- *Developing the Long Term Care and Chronically Mentally Ill components of* ***Soonercare.*** The long term care and chronically mentally ill populations will be the last groups brought into the Medicaid managed care program, with enrollment occurring no earlier than State fiscal year 1998. During the next twelve to twenty-four months, the Medicaid Operations division, in coordination with the Health Policy and Planning division, will develop a separate Section 1115 waiver proposal for these two populations, to be incorporated into the larger ***SoonerCare*** program. The division will also be responsible during this period for oversight of Oklahoma's three existing 1915(c) long term care waiver programs, all of which will

be subsumed by the Section 1115(a) long term care program upon its enactment. Medicaid Operations is being given lead responsibility for this task in part because of the significant long term care experience of the State Medicaid Director, Michael Fogarty.

Health Policy and Planning

The Health Policy and Planning division is responsible for interaction with HCFA on waiver-related subjects, coordination of agency planning, development of all State and federal documents necessary to implement and administer agency programs, including this Protocol, and oversight of the research & evaluation component of *SoonerCare*.

Specific responsibilities for the Health Policy and Planning division include the following:

- *Submitting Supporting Documentation for the Program to HCFA.* The division is responsible for providing information to HCFA, as requested, in support of the *Soonercare* proposal, as well as drafting State Plan Amendments necessary for program implementation.

- *Development of Rates and Rate Methodologies.* The division is responsible for developing fee-for-service rates and supporting methodologies for presentation to the agency's Rates and Standards Committee. Recommendations from the Rates and Standards Committee are presented to the Authority Board for approval.

- *Overseeing Research & Evaluation Acfisities* In collaboration with the Managed Care Division's Quality Assurance Manager, the division will collaborate with HCFA in finalizing the research component of *SoonerCare* and collecting necessary data from MCOs, providers, and consumers to monitor program performance against established objectives.

- *Development of all agency regulations for promulgation.* The division is responsible for coordination of all Medicaid policy presented to the Authority's Board, including all proposed policy related to the *SoonerCare* program, as proposed rules, consistent with federal law, enabling State legislation and the State's Administrative Procedures Act.

- *Developing the Extended Family Planning ~~the SMI/SED components~~ of Soonercare.* The extended family planning population ~~and chronically mentally ill clients~~ will be enrolled into managed care concurrent with long term care. During the next twelve (12) to twenty-four (24) months the Health Policy and Planning divisions will develop a separate ~~Section~~ § 1115(a) waiver proposal for ~~these~~ this group. to be incorporated into the larger *SoonerCare* program. The Family Planning proposal will be developed in cooperation with the Maternal and Infant Health Services Division of the Oklahoma State Department of Health. ~~Services for the chronically mentally ill will be developed in collaboration with the agency's Behavioral Health Coordinator, assigned to the Medical Division, and the Oklahoma State Department of Mental Health and Substance Abuse Services.~~

- *Developing the SMI/SED component of **SoonerCare**.*

1. Urban Areas

During the initial enrollment period and for year two (2) of the ***SoonerCare*** program for the three (3) Urban Catchment Areas, all **AFDC** and AFDC-related individuals - with the exception of children in the custody of the Oklahoma Department of Human Services and Oklahoma Office of Juvenile Affairs - will be enrolled into Managed Care Organizations (MCOs). Subsequent to their enrollment, individuals who are believed to meet clinical criteria, as developed jointly by the agency's Behavioral Health Director. the Oklahoma State Department of Mental Health and Substance Abuse Services. and other clinical experts, which would classify them as being either a Seriously Mentally Ill (SMI) adult or as a Seriously Emotionally Disturbed (SMI) child could be disenrolled from their MCO and returned to the fie-for-service Medicaid Program. The requirements for initiating and accomplishing such disenrollments can be found in **ATTACHMENT # 18.**

Beginning with the third (3rd) year of the ***SoonerCare*** program (July 1, **1997** through June **30.** 1998), clients previously or newly identified **as** being either SMI or **SED** will be given the opportunity to choose to be in the fee-for-service Medicaid Program or enroll into a Health Plan (MCO). Once a client has made a decision to enroll in a MCO. they cannot return to the fee-for-service Program (be disenrolled from the MCO) without the occurrence of a qualifying event (as delineated within the *"Special Enrollment **Provisions**"* section found on page 59 of this Protocol). In order to recognize the additional behavioral health services required by SMI/SED clients as well as recognize the additional expenses which MCOs will incur related to the provision of these additional services, the State will develop and implement an additional package of behavioral health benefits as well as a specific (add-on) capitation payment rate for such services beginning with the third (3rd) year of the Program. The established SMI/SED evaluation tool (Attachment # 18) will continue to be used to identify potential new SMI/SED Medicaid recipients.

2. Rural Areas

Because the State will be capitating only certain services rendered by the Primary Care Physician/Case Manager in the rural catchment area, those clients identified or identifiable as SMI/SED in the rural catchment area will remain in the fee-for-service program for the provision of (related) behavioral health services. They will, however. be included in the PCCM program for physical health related care.

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~~agency's Behavioral Health Coordinator, assigned to the Medical Division, and the Oklahoma State Department of Mental Health and Substance Abuse Services.~~

- ***Administering Special Programs.*** In addition to its other activities, the division is responsible for managing any special policy programs, including grant projects, assigned to the Health Care Authority. In most cases, it is assumed that such programs will be related to the development of managed care systems, particularly in rural communities.

- ***Administration of the State's clearinghouse for health care provider date -- the Division of Health Care Information.*** The Division of Health Care Information is statutorily created and located within the Authority. It is responsible for collection, evaluation, and dissemination of MCO, provider and consumer data related to operation of statewide provider data, including data related to the Medicaid managed care program. This office has been granted authority under State law to collect health data from providers for all population groups, including Title XIX beneficiaries thereby ensuring that comparable information will be available for Medicaid and non-Medicaid recipients in Oklahoma As noted throughout this document, this Division is involved with data collection and analysis of a number of components of the ***Soonercare*** project.

Information Services

The Information Services division is responsible for administering the State's Medicaid Management Information System (MMIS).

Specific responsibilities of the Information Services division include:

- ***Performing Information System Planning.*** The division is responsible for submission of all Advanced Planning Documents to HCFA for the Medicaid program. The division will also oversee implementation of modifications once approved by HCFA.

- ***Overseeing the MMIS.*** The division is responsible for day-to-day operation of the **MMIS,** including collection of encounter data and other minimum data set elements, and production of management reports in support of the Agency's MCO/provider monitoring activities and its research function

- ***Coordinating with the DHS Information System.*** The Information Services division works directly with its counterpart at the Department of Human Services to coordinate transfer of AFDC information system eligibility and enrollment data to the **MMIS.**

- ***Overseeing the State Fiscal Intermediary*** In addition to activities with MCOs and primary care case management physicians, the Oklahoma Title XIX program will continue to process a significant number of fee-for-service claims during the

multi-year phase-in of ***Soonercare.*** Information Services is responsible for overseeing the activities of the State's fiscal intermediary and coordinating fee-for-service claims processing with other management information system activities performed by the division. Information Services is responsible for monitoring all aspects of fiscal agent contracts, performance and quality assurance, systems for approving and denying payments and federally-certified agent status. In addition, in collaboration with the Business and Contracts Manager, the Service conducts reprocurement and also coordinates site performance reviews by HCFA.

Medical Division

The Medical Division functions as an independent unit within the Health Care Authority, with formal reporting responsibility to the Authority Administrator and "dotted line" relationships with the Managed Care Division and Medicaid Operations. This Division is responsible for the following activities:

- Drafting ***SoonerCare*** medical policies and procedures.

- Benefits package development The Medical Director, in collaboration with the Managed Care Division, is responsible for the development of the final capitated benefit packages offered in urban and rural communities.

- Overseeing and monitoring MCO/primary care provider quality assurance and medical management activities (in coordination with the Managed Care and Medicaid Operations divisions), with emphasis in the areas of Maternal/Child Health and EPSDT.

- Conducting periodic medical audits of MCOs/providers (in coordination with the Managed Care and Medicaid Operations divisions).

- Establishing provider participation standards.

- Performing provider relations activities in support of the Managed Care Operations division.

Administrative Support Functions

The Health Care Authority includes five additional Administrative Support functions, all of which report to the Chief of Staff. These functions are:

- ***Personnel.*** Responsible for developing Agency personnel policies and procedures, hiring staff and addressing personnel issues.

- ***Purchasing.*** Responsible for acquiring supplies, equipment, and personal services on behalf of the Agency. Also responsible, with the Business and Contracts Manager,

for executing contracts with MCOs and rural primary care providers, including outpatient networks and rural health networks.

- *Legal Services.* Under the supervision of the agency's General Counsel, the unit is responsible for all Authority legal activities and for coordinating these activities, as necessary, with the State Attorney General's office. In addition, it is responsible for the following activities:

  Formal Grievances & Appeals. The unit operates the program's grievance & appeals process, through which Medicaid beneficiaries, providers, and MCOs seek redress of problems related to claims disputes and enrollment/participation in the managed care program (see section 15).

  Contracting with urban MCOs and rural providers. The Business and Contracts Manager is an attorney. She is responsible for development of Requests for Proposals for MCOs, model MCO contracts and all subcapitated contracts, including the primary care case management contracts. She also oversees evaluations of proposals received from MCOs and capitation rate negotiations. The functions of the Business and Contracts Manager are described in detail in other sections of this document.

- *Fiscal Services (Office of the Comptroller).* Responsible for establishing and maintaining a financial system for the Authority. Also responsible for preparing the Authority's annual budget and overseeing payroll/accounts payable/accounts receivable (including capitation payments to MCOs/rural primary care providers). Responsible for financial reporting and monitoring (see section 13).

- *Public Education and Information.* Responsible for coordinating the agency's public affairs and legislative activities.

Eligibility Determination3

The Oklahoma Department of Human Services (DHS) conducts eligibility determinations for the Authority through its county offices in all 77 counties of the State under an inter-agency agreement. Included in the agreement are provisions that regulations related to eligibility determination, as it relates to certification for medical assistance, will be promulgated by the Oklahoma Health Care Authority Board and adopted by DHS. The Authority and DHS have been meeting on a regular basis, usually every two week, since September, 1994 to identify information system and eligibility system issues, to resolve problems and potential problems and to coordinate eligibility activities and education of clients regarding the program's managed care system. Details of the functions performed by DHS for the Title XIX population are described in greater detail in other sections of this document.

Administrative Relationships between the Authority and MCOs

Significant administrative interactions currently exist between the Authority and MCOs participating under the State's 1915(b) waiver which will continue under the demonstration. This section describes the administrative structures of MCOs as they relate to the Authority.

The Business and Contracts Manager, located in the Legal Division of the Authority, is responsible for all MCO contracts. She is the primary liaison between the Authority and MCOs in all matters related to their contracts. She is also responsible for issuing all notices regarding the failure to meet performance requirements and any assessments of damages under the provisions set forth in the contract. The Managed Care Division and the Medical Division are the primary contacts for all issues outside the contract area.

Under both current contracts and contracts issued under the demonstration, each MCO must designate a Contract Officer who is authorized to represent the MCO in all areas related to implementation and administration of the contract. Contract Officers will be responsible for working directly with the Authority's Business and Contracts Manager.

Mandatory monthly meetings are conducted by the Managed Care Division with senior MCO and Authority administrators both to clarify agency, contract and policy issues and to resolve administrative issues or problems within the MCOs. At these meetings, both MCOs and the Authority identify areas of concern.

MCOs must designate a Medical Director with responsibility for the development, implementation, and review of their internal quality assurance programs and for interactions with the Authority about issues related to provider services. In addition, Medical Directors are responsible for serving as liaisons between the MCO and its providers and for being available to the MCOs medical staff on a daily basis for consultation on referrals, denials, and complaints.

Mandatory meetings are conducted on a monthly basis with MCO Medical Directors and MCO behavioral health administrators. These meetings are chaired by the Authority's Medical Director and representatives from the Managed Care Division. They are held to clarify medical and behavioral health service issues and to resolve general problems which may have arisen within MCOs in these areas.

In addition to attending the monthly meetings, MCO Medical Directors are responsible for working directly with the Authority's Medical Director on a regular basis to identify and resolve issues specific to particular MCOs. The Authority's Medical Director also monitors MCO activities to ensure that:

- Each plan conducts regular utilization review/quality assurance (UR/QA) committee meetings which are chaired by the MCO Medical Director.

- Medical Directors are overseeing the development and revision of health plan medical practice standards and protocols

- Medical Directors are reviewing potential quality of care problems and overseeing development and implementation of corrective action plans

- Appropriate physician recruitment and credentialling activities are being conducted.

MCOs must also have sufficient operating staff to comply with all participation standards described in the contract. At a minimum, MCOs must be able to identify qualified staff in the following areas:

- Executive management, with clear oversight authority for all other functions.

- Medical Director's office.

- Accounting and Budgeting function.

- Member Services function.

- Provider Services function.

- Medical Management function, including quality assurance and utilization review

- Internal complaint resolution function.

- Claims processing function.

- Management information system.

MCOs may combine or sub-contract out functions as long as they are able to demonstrate that all necessary tasks are being performed. Specific MCO responsibilities in each of these areas are described in a number of other sections of this document.

The Grievance & Appeals Officer, located within the Legal Division, is authorized to resolve client and other disputes between MCOs and the State, upon the submission of a request in writing from either party (see section **15** for a discussion of the grievance process).

During the period of each contract, the MCOs must notify the Authority of all changes materially affecting the delivery of care or the administration of its program. The Authority has defined material changes are those which would render an MCO out of compliance with the contract or could affect the MCOs' ability to meet enrollment targets or access standards.

Information Management Systems

State of Oklahoma has had a federally certified Medicaid Management Information System [MMIS] since 1985. The Unisys Corporation has been the State's contractor for fiscal agent services. Oklahoma submitted a formal Advanced Planning Document (APD) to HCFA November 3,1994, to allow the incorporation of managed care processing into the MMIS system. The APD was approved, and a sole source contract was awarded to the State's existing fiscal agent, Unisys, in November 1994. The State and Unisys jointly developed the specificatims, completed a formal Systems Requirement Document this March 3, 1995, and in June 1995 installed the actual information system components to support managed care for the 1915(b) waiver. If requested, the State will furnish a copy of the APD or the Systems Requirement Document.

The State began technical and functional design meetings to handle managed care implementation in June 1994. The guidelines for the design efforts have been the managed care models specified in the 1915(b) waiver and also those in the 1115(a) waiver. Specific edits for the 1915(b) waiver are currently in place and will be replaced with 1115(a) edits when that waiver starts. Enrollment for the 1915(b) waiver started July 1, 1995, and health care delivery began August 1, 1995. The State has already implemented a significant number of MMIS upgrades to support the managed care operations already in place. The following items are some of the more significant changes made to the State's MMIS.

- Identify recipients on the recipient master file enrolled with managed care in the urban areas and to which MCO the recipient is assigned on a monthly basis. Thirty-six months of enrollment data will be stored on-line in the recipient master file. Monthly capitation adjustments will be processed against claims received and will be deducted from the MCO the recipient was enrolled with at the date of service for the claim.

- Accept managed care enrollment data from the State's enrollment agent, Benova Inc., in an electronic format. Benova operators process telephone enrollments and record the recipient's enrollment information in Benova's data system. Each night a data file is sent from Benova to the State's fiscal agent.

- Update the managed care enrollment data on the recipient master file from the enrollment agent data. The data file sent by Benova to Unisys is applied to a file that records selections made by recipients who will not be auto-assigned as a result.

- Update the managed care enrollment data on the recipient master file from the enrollment cards received from the recipients provided at the DHS county offices.

In certain circumstances, OHCA will mail enrollment packets directly to recipients. These recipients making a selection will not be auto-assigned.

- Upgrade REVS (Recipient Eligibility Verification System) to indicate managed care enrollment data along with Medicaid eligibility information. REVS will detail eligibility information and, for managed care recipients, REVS will now indicate enrollment with a specific MCO or PCCM provider.

- Process recipients changing from one MCO to another MCO. Under the 1915(b), recipients can change MCOs on a monthly basis. Under the 1115(a) waiver, recipients can only change MCOs in the first 30 days of enrollment except for an approved cause.

- Identify recipients on the recipient master file enrolled with managed care in the rural areas and which PCCM or Outpatient Network the recipient is assigned on a monthly basis. Thirty-six months of enrollment data will be stored on-line in the recipient master file. Monthly capitation adjustments will be processed against claims received and will be deducted from the PCCM or Outpatient Network that the recipient was enrolled with at the date of service.

- Process recipients moving from one catchment area to another catchment area. Recipients that move from one of the urban areas to a separate urban area will be enrolled in the same MCO if available in the new catchment area. If the original MCO is not available in the new catchment area, the recipient will be given the opportunity to select a MCO in the catchment area that has coverage which includes the recipient's new address. The former MCO will automatically be sent a closure.

- Process recipients moving from one rural area to another rural area. Recipients that move from one part of the rural area to another rural area will be given the opportunity to select a new managed care provider in the geographic proximity of the recipient's new address. The former managed care provider will automatically be sent a closure.

- Process recipients moving from a urban catchment area to a rural managed care area. Recipients that move from one of the urban catchment areas to a rural area will be given the opportunity to select a managed care provider in the geographic proximity of the recipient's new address. The former MCO will automatically be sent a closure.

- Process recipients moving from the rural area to an urban catchment area. Recipients that move from the rural area to one of the urban catchment areas will be given the opportunity to select a MCO in the catchment area of the recipient's

new address. The former managed care provider will automatically be sent a closure.

- Generate daily rosters to be sent electronically to MCOs. Membership adds, changes, and deletes will be sent to the MCOs each business day. Since the volume is so high, daily transactions are sent to give participating MCOs time to process the enrollment, allow time for the recipient to select a primary care provider, mail the recipient a membership handbook, and create and mail a MCO membership card.

- Generate monthly rosters to be sent electronically to MCOs. A cumulative roster of recipients assigned to each MCO will be compiled monthly from the recipient master file. The MCO roster will be sent as an electronic data file. All MCOs are required to reconcile the monthly roster to their enrollment database. MCOs have 15 working days to notify the State of any discrepancy between the State's enrollment information and enrollment data on the MCO's database.

- Calculate a monthly prospective capitation payment for each MCO based on the age and sex of the recipients. The recipients enrolled with the MCO that are detailed on the monthly roster will become a payment to the MCO. Adjustments will be subtracted from the capitation for out of network family planning, child abuse exams, and EPSDT.

- Pay MCOs through the State's electronic funds transfer (EFT) system. The adjusted capitation amount will be paid to the MCO through the State's electronic funds transfer.

- Generate a monthly roster to be sent to each rural managed care provider. A cumulative roster of recipients assigned to each PCCM or Outpatient Network will be compiled monthly from the recipient master file. The PCCM or Outpatient Network will be sent a printed report of membership. These rosters will be mailed to PCCMs along with the monthly captitation statement of remittance.

- Calculate a monthly prospective capitation payment for each rural managed care provider based on the age and sex of the recipients. The recipients on the monthly roster will become a payment to the PCCM or Outpatient Network. Adjustments will be subtracted from the capitation for family planning and EPSDT procedures performed by another provider. The adjusted capitation amount will be paid to the PCCM or Outpatient Network.

- Generate a capitation remittance advice statement for rural managed care providers. Capitation payments to PCCM or Outpatient Network providers will be detailed as itemizations on the managed care statement of remittance which

will be mailed along with the check to the provider. Providers using the State's EFT system will only receive the managed care statement of remittance.

- Upgrade the electronic claims management system to accept electronic encounter claims from MCOs. MCOs must send a monthly data file to the State's fiscal agent. The electronic claims management system will be upgraded to accept the data file containing the encounter claims from a MCO.

- Modify the claims database to accept encounter claims for managed care from a MCO, Outpatient Network, or PCCM provider. Encounter claims will be processed into the claims database as "history" only claims. Claims will be adjudicated at the current Medicaid fee schedule for future reporting of managed care costing.

- Provide MCOs with an electronic edit report on encounter claims submitted to the State's fiscal agent. The MCOs will be sent an error log that will allow the MCOs to correct the errors in submitted encounter claims. The data file sent by the MCO must be relatively free from edit errors to be accepted into the claims database (90 percent of data must be error free).

- Update MARS reports to handle encounter data and report the managed care payment amount. MARS will be enhanced to recognize history only encounter claims submitted monthly by MCOs. MARS reports will have new line items that report the monthly capitation payments.

- Calculate stop loss on recipients for participating MCOs. The State has two types of stop loss: mental health stop loss and all other medical claims stop loss. The mental health stop loss is $25,000 per member per contract year. The medical stop loss has a $25,000, a $50,000 and a catastrophic stop loss of $250,000. Claims received will be processed and accumulated against the various limits. After reaching a stop loss level, reports will be sent to the Medical Director for stop loss payment approval. Stop loss payments will be made after the approval is given. The stop loss payment will be part of the MCO monthly managed care statement of remittance and will be paid as a part of the monthly payment mechanism. The State does not have any MCO participating this contract year with the State's reinsurance program.

- Calculate stop loss on recipients for each rural managed care provider. The State is currently working with its actuary to develop a stop loss limit for PCCM and Outpatient Network providers. Claims received from a PCCM or Outpatient Network will be accumulated against the stop loss limit. After reaching a stop loss level, reports will be sent to the Medical Director for stop loss payment approval. Stop loss payments will be made after the approval is given. The stop

loss payment will be part of the PCCM monthly managed care statement of remittance and will be paid as a part of the monthly payment mechanism.

- Make monthly reinsurance calculations for MCOs participating with the State's reinsurance program. The State will make a negative adjustment on the MCO managed care statement of remittance for the reinsurance. The State does not have any MCO participating this contract year with the State's reinsurance program.

- State added a process to the MMIS that will perform "Open Enrollments'' for managed care recipients. Yearly open enrollments will be done for the rural portion of the state and for the urban areas. The State is anticipating two months of open enrollment. The State will operate a one month open enrollment period for the urban areas and a second month for the rural portion of the state.

Most of these enhancements were necessary for the State to manage the 1915(b) waiver program. Additional changes will be made to coincide with the implementation of the 1115(a) waiver that incorporate the items specific to the 1115(a) waiver such as six months guaranteed eligibility and the 12 months lock-in.

9. ENCOUNTER DATA COLLECTION AND REPORTING

Introduction

The State has currently developed a process for the collection of encounter data and its use in improving the efficiency and quality of health care for Title XIX recipients. If Medicaid HEDIS is approved in a substantially comparable form to the draft format released in July, 1995, it is anticipated it will become the basis for much of the encounter data necessary for utilization review and focused studies on quality.

Overview

MCOs and primary care providers have 45 days after the end-of-month to submit encounter data to the State. Service delivery started August 1, 1995 for the three catchment areas under the 1915(b) waiver. MCOs must report the encounter data for clinical services provided during August by October 15, 1995. These datasets will be submitted in an electronic format to the State's fiscal agent. The datasets will go through an edit process and be applied to the MMIS claims system as history only claims. The State's fiscal agent, Unisys Corporation, will operate the computer operations. The MCO contract includes a $2,500 per day financial penalty for non-compliance that will motivate the MCOs to submit their data to the State in a timely fashion. Primary care providers will also have 45 days to submit their claims. Since stop loss payments for procedures inside of the PCCM benefit package will be calculated from encounter claims submitted, primary care providers will have a financial incentive for submitting their encounter claims to the State. Also for PCCM providers, procedures outside of the benefit package can only be paid from encounters submitted to the State. The State believes that the urban MCOs, the Outpatient Networks, and the PCCMs have a strong financial incentive to comply with the encounter date reporting requirements. The State will use existing fee-for-service utilization rates as a means to compare the adequacy of encounter submissions to the State from all managed care providers.

MCOs and Outpatient Networks (both urban and rural) will be required to submit all data in an electronic media format. The reports to be submitted include: HCFA-1500, UB-92, EPSDT form (ADM-36-K), Transportation form (ADM-84), NCPDP format for prescribed drugs from point-of-sale, and Dental services form (ADM-36-D). Over one hundred pages of data element definitions and technical specifications have already been given to the participating MCOs. The State will be glad to furnish the technical data set definitions upon request.

Information Services Division of the Oklahoma Health Care Authority will monitor the transmission of encounter data to ensure the data files are sent within the contractual time limits and verify the completeness of the transmission. The State's fiscal agent has a batch edit program that will preprocess the encounter data file received monthly from the MCOs. The preprocess will reject the entire data file as invalid if the error rate exceeds

10 percent. An edit report listing all errors will be produced and sent to the MCOs. If the data file was rejected, the MCO can use the edit report to correct the data and resubmit to the State's fiscal agent. MCOs that submit data files to the State will use the edit report to improve the quality of their data submitted. The State conducted five technical conferences with the MCOs before contracting with the MCOs. The intent was to educate the MCOs about all aspects of the State's reporting requirements. Quality Assurance Manager will be assigned the responsibility to monitor data appropriateness and to work with the external peer review organization, Oklahoma Foundation for Medical Quality (see section 7 for QA/UR procedures) to improve health care outcomes.

Partially-capitated rural providers will be required to submit all the same data elements and forms to the State as MCOs for items in their benefit package. Items outside of the benefit package will be submitted to the State as a fee-for-service claim and will therefore be a regular claim. Since the size of many rural practices is limited to one or two individuals, the State will not mandate electronic submittals of data. However, it should be noted that approximately 80 percent of all claims today are sent to the State in electronic media formats.

Data received from the fee-for-service system and from the managed care system will be merged into an integrated claims database. Managed care encounters will be identified as such and will be reported separately from fee-for-service claims. The State will use the data collected to operate the study projects identified in the waiver.

- ⇒ Childhood immunizations;
- ⇒ Prenatal care and birth outcomes;
- ⇒ Pediatric Asthma
- ⇒ Comprehensive Well child Periodic Health Assessments.

The Oklahoma Foundation for Medical Quality, the State's external independent review organization, will provide the State and MCOs with data reports on the focused studies and on utilization reviews. Working in conjunction with the Oklahoma Foundation for Medical Quality the State will use the encounter data for determining changes needed in benefit package or managed care reporting requirements. Refer to section 7 for more detail concerning Quality Assurance and Utilization Review (QA/UR) data, reporting, and monitoring.

The State, in spring 1996, will implement and maintain a new Executive Information System/Decision Support System (EIS/DSS) and enhance current ad hoc reporting capabilities. EIS/DSS will allow OHCA to take full advantage of the breadth and depth of Medicaid -- managed care data resident on the MMIS. EIS/DSS will allow OHCA to more effectively manage the complexity and scope of the Oklahoma Medicaid managed care program and to aggressively contain costs while ensuring access to medically necessary, quality health care.

The EIS/DSS will provide a relational database management system (RDBMS), an executive information system (EIS), and a decision support system (DSS) and will reside on fiscal agent hardware. EIS/DSS capabilities will be used to support the planning, monitoring, and evaluation of program operation and performance. The EIS/DSS will support the systems activities and professional services necessary to meet and exceed all State and Federal reporting needs:

- ⇒ Program management, financial analysis, and ad hoc reporting
- ⇒ Analysis of access and quality of care in managed care programs
- ⇒ Audit support
- ⇒ Analysis and reporting of access, quality, use, and cost of care.

The State will use the EIS/DSS computer system to validate that encounter reporting is comparable between MCO, Outpatient Network, PCCM providers and fee-for-service providers. Financial sanctions discussed earlier will be imposed against entities that do not meet the reporting standards established by the State.

A number of other data sources will be collected and used by the State. These include the following data:

- ⇒ Per capita expenditure and utilization data
- ⇒ MCO reports
- ⇒ Member satisfaction surveys
- ⇒ Medical record reviews
- ⇒ Plan and provider surveys
- ⇒ Data from program monitoring activities
- ⇒ Health status information as reported by enrollees
- ⇒ Outcome-based clinical reporting by MCOs
- ⇒ Morbidity and mortality reports and epidemiological data obtained from the Oklahoma State Department of Health; Provider information collected through the Division of Health Care Information
- ⇒ Information regarding prenatal care experience, utilization patterns and pregnancy outcome through the Pregnancy Risk Assessment Monitoring System.
- ⇒ Related initiatives such as the "Healthy Futures Program," "Improving Health of Native Americans," and "Building Bridges for Better Health."

Description of Data Sources

Per Capita Expenditure and Utilization Data

Per capita expenditure and utilization data will be used to monitor the success of the program in terms of improving access to care while achieving cost containment. There will be two primary sources of data: 1) the State's Medicaid Management Information System (MMIS); and 2) encounter reporting by prepaid MCOs and rural primary care providers, including reports of primary care visits and specialty referrals. In keeping with

QARI Guidelines for Internal Quality Assurance, MCOs will be required to maintain, and submit on an aggregate basis, encounter data that reports levels of utilization and expenditures for the Title XIX population.

The State will define separate minimum data sets for MCOs and partially-capitated providers and require this data to be reported on a pre-established schedule. The State will also compile fee-for-service specialty and inpatient claims data from its MMIS to supplement the information reported by rural primary care providers. The State will conduct periodic audits of MCO data and provider data, including validation studies, to ensure compliance.

MCO Reports

These reports will contain basic information regarding MCO Quality Assurance Plans, including the identification and resolution of quality of care issues, findings from focused studies, and data for credentialling and recredentialling activities.

Member Satisfaction Surveys

As specified in the QARI Guidelines for Internal Quality, the State will develop a member satisfaction survey process, designed to collect information on client satisfaction with plan service, providers and, care received. **A** random but statistically significant sampling of clients will be asked to respond to questions in the following areas:

- ⇒ Overall satisfaction with plan or provider
- ⇒ Satisfaction with care provided
- ⇒ Access to primary care
- ⇒ Access to specialty services

Medical Records Reviews

As specified in the QARI Guidelines for External Quality Review III.A., medical records analyses will be conducted to assess the health status of participants and to evaluate the quality of care provided under the program. The analysis will consist of evaluating changes in health status based on medical record documentation of encounters, including, but not limited to: Preventive services; telemedicine usage; admission and discharge data; information regarding treatments provided **and** referrals made; and outcomes within clinical areas of interest.

Plan and Provider Surveys

QARI guidelines recommend studying contractor participation in the State's MCO system. A survey of participating plans will be conducted to assess the level of satisfaction with the program. Survey data will be used to make program changes necessary to maintain adequate levels of participation and satisfaction among MCOs.

Similarly, individual providers will be surveyed to determine their level of satisfaction with financial, administrative, and operational components of the program. Provider surveys will focus on quality of care, professional latitude, telemedicine utilization, utilization management within the program and potential for program improvement.

For both plans and providers, the State will seek to determine the key factors affecting the decision to first participate and then remain in the program. The State will also conduct random surveys of non-participating providers to determine why they have declined to participate.

Data from Program Monitoring

Pursuant to QARI required elements for State monitoring, III.B, data will be collected from participating MCOs and providers throughout the demonstration. This data will be used to supplement encounter reporting-based data and will include financial information necessary to measure each MCO's overall viability. Reference section 7 for additional details about QA/UR and section 13 for financial reporting.

Health Status Information Reported by Enrollees

The State will use a brief assessment tool, such as the "Short Form 36," to collect data on the self-reported health status of program enrollees. The form will question enrollees regarding any existing or chronic health problems, date of last encounter with a health care provider, hospitalizations in the past year, etc.

Outcomes-based Clinical Reporting by MCOs

MCOs will be required to report outcomes-based findings and information as specified by the Medicaid program and the Division of Health Care Information in the QARI Guidelines for Internal Quality Assurance Programs.

OSDH Morbidity and Mortality Reports and Epidemiological Data

Data is available through the Department of Health related to morbidity and mortality of Oklahoma residents. Comparative analysis may be conducted of the health status of the Medicaid population, as reported by MCOs and rural primary care providers, compared to the health status of the population at large. In addition, epidemiological data available through the Department of Health may be used to conduct a similar comparison.

Provider Information Collected through the Division of Health Care Information

The Health Care Authority's Division of Health Care Information is required by statute to collect and disseminate information from health care providers regarding health care utilization, expenditures, financing mechanisms, and service delivery. These are also QARI requirements for External Quality Reviews. This information may be used to

compare Medicaid clients to other population groups, as well as to examine specifically Medicaid beneficiaries and Title XIX-related services.

Pregnancy Risk Assessment Monitoring System (PRAMS) Data

Information obtained through PRAMS surveys will be evaluated to measure improvements in the health status and prenatal care patterns of women served through the Medicaid program. It will also be used to compare Medicaid recipients with those women whose pregnancy-related health care is funded through other sources.

10. INCLUSION OF FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CENTERS IN *SOONERCARE*

Introduction

This section of the operational protocol describes the ways in which Oklahoma will encourage the participation of Federally-Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in ***SoonerCare*** and will assure the availability of their services to beneficiaries. Policies for the MCO and rural partial capitation service areas are discussed separately.

MCO Sewice Areas

Federally-qualified health centers (FQHCs) operating in areas served by MCOs, including urban Indian clinics such as the Tulsa Indian Health Center, will have several managed care participation options options. First, FQHCs will be free to align with other providers or with risk-bearing entities to create new state-licensed, ,repaid health plans. Any such new MCOs then would be able to submit proposals to participate in the ***Soonercare*** program during the next contract period, scheduled to begin July 1, 1996.

As a second alternative, FQHCs could elect to participate in ***Soonercare*** by serving as providers in networks operated by other organizations. To facilitate this option for FQHCs that do not establish their own health plans, the State as a general rule will require MCOs to contract with FQHCs in their service areas. This requirement is already in place for the 1915(b) program and, during last Summer's procurement, the existing FQHCs in Oklahoma City and Tulsa became contracted providers with every MCO participating in ***Soonercare*** (there are no FQHCs in Comanche County).

As a general rule, the State will continue to require its MCOs to contract with FQHCs in their service areas under the 1115(a) program. The only exception will be for health plans that can demonstrate to the State that they have adequate capacity and will provide an appropriate range of services for vulnerable populations through other mechanisms.

In cases where a plan requests to be relieved of this requirement, the State will submit to HCFA a report documenting this request at least ***60*** days prior to submission of the final managed care contract for HCFA approval. In preparation of the report, the Authority will conduct an analysis of the MCO's ability to deliver appropriate services without contracting with FQHCs. This analysis will include two major factors.

First, HCFA requires any plan without FQHCs to demonstrate that it has sufficient provider capacity to serve the populations currently receiving care at FQHCs within the service area. To verify that an MCO has such capacity, the Authority will quantify the numbers of potential managed care enrollees receiving services through FQHCs, as well as the locations and capacity of all non-FQHC network providers who are delivering the

same package of services (the non-FQHC provider information will be extracted from network profile data which MCOs are required to submit as part of their responses to RFPs)

The Authority will then use the GEO Access computer program to plot recipients and providers, by service type. In its analysis, the Authority will verify that sufficient capacity is present within the network to ensure that all recipients, including FQHC patients, have access to primary care physicians with additional capacity practicing within 5 miles of their place of residence.

The Authority will next analyze the ability of the plan to provide a comparable level of Medicaid services (other than primary care) to what is actually being delivered by the FQHC, including covered outreach, social support services, and culturally sensitive services, such as translators and training for medical and administrative staff. MCOs will be required to document in their request whatever comparable outreach and case management they intend to conduct to achieve a level of cultural sensitivity equivalent to what is available in the FQHC.

If the State, with HCFA's approval, chooses to allow an MCO to operate without FQHC providers in its network, it will limit this exemption to one year in duration. Should the MCO wish to continue to operate beyond that year without FQHCs, it will be required to submit a new request, with updated documentation, prior to expiration of the exemption. During its normal oversight of plan activities and during its annual on-site operational review of health plans, the State will monitor the actual level of service accessibility in the MCO and will intervene immediately if problems are identified. As part of any corrective action plan it might issue, the State would reserve the right to withdraw its exemption and require the MCO to contract with FQHCs within some specified timeframe.

Although not directly related to the question of FQHC contracts, it should also be noted that Oklahoma's existing 1915(b) contracts include a number of provisions designed to ensure access to culturally-sensitive providers, and such requirements will be retained in similar or identical form under the 1115(a) program. First, under the current program, plans have been required to contract with providers in a wide variety of service categories (e.g., physicians, mental health clinics, pharmacies, etc.) who have historically served the Title XIX population, including providers serving minority racial and ethnic groups.

In addition, during interviews for certification for Title XIX services, State case workers determine the primary language of applicants. Health plans are then required to have written material and interpreter services available whenever there are 100 members or 10% of the health plan's Title XIX membership, whichever is greater, who speak a language other than English as their primary language. Health plans are also encouraged to list languages spoken by their providers, and many have done so.

With respect to FQHC payment, the Terms and Conditions for the 1115(a) demonstration require that health plans pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. At the time of submittal of the health plan RFP to HCFA for its review, the State will provide a description of the payment methodology for FQHCs and will ensure it is consistent with this language.

Rural Partial Capitation Service Areas

Rural health clinics (RHCs) and rural federally-qualified health centers (FQHCs) will be permitted to participate as primary care providers in the PCCM system under special participation terms. Centers and clinics will be free to serve as primary care providers in a program model that would limit their risk to the cost of federally-qualified primary care and gatekeeping services. In addition, private physicians within rural communities who participate as primary care physician/case managers and are responsible for furnishing case management services, will be permitted to refer to rural RHCs/FQHCs, for medically necessary specialty and ancillary services.

RHCs and FQHCs will also be free to participate in Outpatient Networks (when established) or to assume risk on their own for a broader range of outpatient health care services, similar to the outpatient network model. Under this option, which will not be available before SFY 1997, all services provided by the center/clinic will be included under a single capitation rate.

▮▮ - SERVICES FOR AMERICAN INDIANS

This section will be completed and submitted to HCFA by October 31,1995.